



# Second Chance at Life

## Transplant Related Expenses & Insurance Grants

The following list is reasonable transplant related expenses that the organization will fund. Which one(s) are you applying for? Please check all that apply.

- Prescription drugs necessitated by the transplant for the patient.
- Medical bills and/or co-pays related to the transplant patient.
- Dental assistance for pre-transplant candidate.

**These items are not considered transplant expenses and will not be reimbursed:**

- \* Entertainment items
- \* Clothing
- \* Personal Products
- \* Rehab therapy not administered by a licensed therapist
- \* Postage
- \* Auto repairs
- \* Computers
- \* Loss of income
- \* Expenses unrelated to transplant

*Please note this is not a completed list of expenses and the charity does not reimburse the individual.*

**Guidelines for funding:** In order for your application to be considered, the following items need to accompany your application:

- Proof of Michigan residency during the last twelve months prior to this application date. Proof of residency can be a utility bill, bank statement or a driver's license with the expiration date.
- Proof of Income – You may either enclose a copy of the most recent State Income Tax or a most recent check stub or social security income statement.
- Proof of Health Insurance if applicable – A copy of your Medicare, Medicaid or private insurance card. If you don't have health insurance, please note that you have no insurance.
- Invoices/quotes for all medical related expenses that you are seeking the charity to pay the company/creditor directly: Examples: Copy of medication prescribed and costs, copy of medical invoice or quote from dental office.

**Date of Application:** \_\_\_\_\_

**Applicant's Signature:** \_\_\_\_\_

**Please Print Name:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_



# Second Chance at Life

## Client Information Section:

First Name

Middle

Last Name

Street Address

Apt./Suite Number

City

State

Zip Code

County

Home Phone

Cell Phone

E-Mail

Date of Birth

Age

Male

Female

Married\*

Single

\* If married, please provide your spouse's name \_\_\_\_\_

Number in Household

Number of Children (living in household)

## Demographical Information:

Transplant Center

Date of Transplant

Organ

### Current Source of Income (Please check all that apply)

Full-Time employment

with benefits

Social Security Disability (SSDI)

Part-Time employment

with benefits

Supplemental Security Income

Other \_\_\_\_\_

**Current Healthcare Coverage – Please list what type of insurance you have, if none, state none.**

### Check all that apply:

Recipient

Candidate

Living donor

How did you hear about Second Chance at Life? \_\_\_\_\_

*Do not leave any field blank*

## Financial Assistance Application

**Assets** Do not leave any field's blank in this section

Checking Account \$ \_\_\_\_\_  
 Savings Account \$ \_\_\_\_\_  
 Retirement \$ \_\_\_\_\_  
 Other \$ \_\_\_\_\_

**Monthly Household Income**

\*(please read below)

**Monthly Household Expenses**

\*(please read below)

<b>Wages (net)</b>		<b>Rent/Mortgage</b>	
<b>Social Security</b>		<b>Food</b>	
<b>Pension</b>		<b>Utilities Total</b>	
<b>Spouse's Income</b>		<b>Auto Payment/Gas</b>	
<b>Retirement Income</b>		<b>Insurance – Medical</b>	
<b>Dividends if applicable</b>		<b>Insurance – Life</b>	
<b>Other (specify)</b>		<b>Insurance – Auto</b>	
		<b>Charge Accounts</b>	
		<b>Other</b>	

**Total Monthly Income:** \_\_\_\_\_ **Total Monthly Expenses** \_\_\_\_\_

I authorize information released between Second Chance at Life and my transplant Center or other related parties to verify information related to this request. I agree to be added to Second Chance at Life for future mailings.

Applicants Signature

Date

If your monthly expenses are more than your monthly income, please explain how you are paying your bills each month: \_\_\_\_\_

\* **Income:** Total amount for wages or salary, self-employment, pensions, rental income, income from lawsuit, unemployment income, Social Security, Social Security Disability Income, child support, public assistance and any income from working spouse, children, parents, siblings, grandparents, renters or any other person(s) related or non-related residing in your household.

\* **Expenses:** General household expenses per month-rent/mortgage, food, utilities, phone, credit card(s) monthly amount paid (not balances owed).

